

THE VALUE OF STORY THEORY IN PROVIDING CULTURALLY SENSITIVE ADVANCED PRACTICE NURSING IN RURAL APPALACHIA

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ABSTRACT

This paper is based on the premise that nurses come to terms with the realities of patients by forming an understanding of their cultural viewpoints through embracing the person's story. The author presents her journey in coming to understand the importance of attending to the patient's story in the delivery of advanced practice nursing. Highlights of the journey include: a reconstructed story of a woman deeply immersed in the cultural and religious traditions of Appalachia; literature on Appalachian culture, religious practices, and beliefs; and story theory as a theoretical approach to guide culturally sensitive nursing practice.

Key words: Appalachian Culture, Story Theory, Advanced Practice Nursing

INTRODUCTION

The focus of nursing is caring in the human health experience (Newman, Sime, & Corcoran-Perry, 1991). Each caring relationship is unique, as nurse and patient are both individuals, shaped by past experiences, environment, and the cultural orientation of their people. Culture is the lens through which the world is viewed. When people of different cultures interact, each may find the other's cultural perspective foreign and illogical. The human health experience is shared within the nurse-patient relationship and the focus of the experience is the health concern of the patient. The nurse is called to visualize the experience from the patient's point of view. Story theory (Liehr & Smith, 2008) proposes a structure to guide the nurse-patient health promoting process. As the patient's story unfolds, beliefs and values underpinning health choices are illuminated.

The neomodernist perspective holds that all are born into the ongoing story of history (Reed, 1995). Every individual has a story, unique in its own right, which contributes to that history. Nurses come to terms with the realities of the patient by forming an understanding of cultural viewpoints and appreciating the underlying values and meanings to which that particular culture gives voice.

Appalachian culture is unique to the rugged, mountainous region of the eastern United States. Stereotypes of this culture range from the ridiculous to the romantic. The traditional, fundamentalist mountain religions practiced by many Appalachians tend to be misunderstood. Jones (1999) writes that "No aspect of Appalachian life is as misconstrued and misrepresented as that of religion" (p. 401). Appalachia is home to a number of mainstream religious denominations as well as independent self-sustaining churches that are loosely affiliated with the Church of God, Pentecostal or Holiness religions. Despite the fact that the Pentecostal movement originated in California and is now one of the largest and fastest growing denominations in the world, this religion is assumed by many to be an Appalachian institution. Church of God, Holiness, and Pentecostal churches may embrace religious practices such as snake handling, fire

handling, and drinking of poisons (McCauley, 1995). Some religious practices and beliefs that are accepted by many Appalachians may seem peculiar to others.

This paper is based on the premise that when these practices and beliefs are understood through story theory from the perspective of the patient, nurses will be better able to provide culturally appropriate care to Appalachian patients. The paper will portray the author's journey in coming to understand the importance of attending to the patient's story in the delivery of advanced practice nursing. The following highlights of the journey will be presented: 1) the reconstructed story of a woman deeply immersed in the cultural and religious traditions of Appalachia, 2) literature on Appalachian culture, religious practices, and beliefs, and 3) story theory as a theoretical approach to guide culturally sensitive advanced practice nursing.

MOLLY'S STORY

The story was gathered by the advanced practice nurse. First, Molly wrote about her life in a rural Appalachian coal mining community. Then the story was developed further through dialogue in clinic visits. The story that follows is the reconstructed story created by the nurse while staying true to the patient's voice.

Molly's fifty years have been spent within twenty miles of the family home place, a rambling old house that was originally a shotgun style cabin, situated deep in the coal fields of Appalachia. Molly's was the traditional Appalachian family. Her father was a coal miner, working for years in both union and non-union mines, usually underground where the coal seams were narrow. Many of his working hours were spent on his knees. Years of working "low coal" left him with arthritic knees and a perpetual stoop. Molly's mother was a homemaker and lay preacher in the local Holiness Church. Molly recalls family stories of her mother's activities in the church during Molly's younger years. Her mother admitted a call to the ministry only in her later years, but attended prayer meetings in the homes of church members when Molly was a little girl.

Prayer meetings held in homes were more informal than those held in the actual church building, and Molly's mother was actively involved in these more spontaneous, less structured gatherings. These meetings were often held in the homes of those who were too ill or incapacitated to travel to the church for formal services. In those days, many homes were heated by pot bellied cast iron stoves that burned coal. Molly said that one home where prayer meetings were frequently held had a particular sort of coal burning stove. It was not a typical stove in that the sides were open and the coals were easily accessible. Molly remembers people being touched by the Spirit during the prayer meetings and dancing around this open stove and never getting hurt. The family told the story of the time Molly's mother was touched by the Holy Spirit and reached into this stove and pulled burning coals from the fire with her bare hand. She was unharmed. Molly recalls her mother as a woman of great faith.

Molly remembers the praying at these meetings. The elders, preachers, and those who felt they had the gift of healing would pray and anoint the sick with Holy Oil. The Holy Oil had in turn been prepared for anointing by being prayed over by a group of church members. Small squares of cotton cloth were anointed with Holy Oil or Water and prayed over. Then they were given to the physically or emotionally afflicted to wear as prayer clothes or talismans for protection against the evils and dangers of the world. Molly's mother was believed to have had the gift of healing and discernment. As a healer, the Holy Spirit would move upon her and she would lay hands upon the afflicted person, praying for God's intervention. The afflicted would in

turn be touched by the Holy Spirit, and “fall out in the Spirit”, dropping to the floor or the waiting arms of those praying for them. No harm came to them from the fall. It was seen as a miraculous experience. The gift of discernment allowed Molly’s mother to look into the heart of an individual and determine if that person’s heart was truly focused on God or still leaning toward the world. When the Holy Spirit moved upon her it was not unusual for her to speak in tongues. Molly’s mother was greatly respected by her fellow church members.

In her younger years, Molly’s mother did not believe in seeking the services of health care providers. She believed along with others in her church that turning to others indicated a lack of faith in God and His power to heal. This was a prime example of “leaning on the arm of man” instead of trusting God to do as He had promised. People who did go to health care providers were looked down on as lacking in faith, and faced a certain degree of shunning by those who held steadfast to the Word.

After her children were born Molly’s mother became more tolerant of modern health care practices. While she and her husband continued to avoid contact with physicians, she did insist that the children have their immunizations, and took them to the local clinic when injured or ill. When Molly was eight years old, she recalls assisting her mother in preparing the main meal of the day. The meal was taken at noon since her father worked the evening shift at the mine. Molly spilled an iron skillet of hot lard over her left arm. She sustained serious burns and was ultimately taken to a neighboring state for skin grafts. Although she retained full use of the limb, it remained puckered and scarred. Her mother prayed for her recovery, while at the same time, did not hesitate in getting health care for Molly. Being very young, Molly found these actions to be inexplicable. It seemed her mother acted on a double standard. She never questioned her mother as to why she would practice and preach faith healing but still insist that Molly obtain modern health care. Molly remained strong in her faith, and still believed her mother to be blessed by God to heal. Yet in her mind and heart, there were questions, if not doubts.

Molly was baptized into the Holiness church at a revival as a teenager. Church was a social as well as spiritual gathering. Daily life was centered on church events. Molly attended Sunday school, homecomings, foot washings and partook of the sacrament. As she matured, she too, was touched by the Holy Spirit and would speak in tongues. She did not acquire the gift of healing, but saw her music and writing abilities as her contribution to the church. Her religious upbringing as a child would provide her with a much needed haven and support in the years to come.

Molly’s parents did not start seeking health care until late in their lives when they became afflicted with chronic and ultimately life threatening diseases. Her parents continued to go to church and requested anointment and prayer regularly. They also began going to the local clinic for testing and treatment. Her mother was diagnosed with breast cancer and had a double mastectomy. At one point, she was hospitalized and her prognosis was poor. She said that God came to her in the spirit and told her she would not yet die. Molly’s father was diagnosed with prostate cancer. He was taken to a nearby hospital for testing. While there, a stranger offered to pray for him. The family did not know the man, and they never again saw him after that day. Molly said that as the stranger prayed the cancer left her father’s body, and subsequent testing failed to find any indication of prostate cancer. Molly’s father preceded his wife in death, and died of pneumoconiosis and lung cancer. Molly’s mother lived for years after her breast cancer treatment, and told her children that God had promised her that she would die on the anniversary of her husband’s death. She died at home with pneumonia, and as she foretold, she died the same date of the same month in which her husband had died years earlier.

Molly's sisters married young and left the State. Her brothers followed her father into the mines. She had an extended network of kinfolk living nearby. Molly graduated from the local high school, and married her first and only serious boy friend. He too became a coal miner. Molly held a job in her home community. During her young married life the mines were prospering and the coal miners' union was at its peak. Money was good and the town flourished. There were many stores, a hotel, car dealership, and even a movie theater. The local community health clinic was one of the best equipped and staffed in the State. The miners had excellent insurance coverage.

Her life seemed to be storybook complete. She and her husband bought a house and had a son and a daughter. They both continued to work. Molly remained active in the Holiness Church, and her husband attended sporadically. She organized the church youth group, played electric bass in the church band, and directed seasonal dramas. Her children were also active in the church. They grew up without mishap and graduated from the same high school their parents had attended. Their son followed his father into the mines. The daughter married young and started a family. The cycle of mountain life was repeating.

However, within the region things were changing. The coal industry was in a decline, and local mines began to shut down. The local economy was dependent on the coal industry. The distance between this region and industrial areas where jobs still were available made commuting difficult. There were no alternative jobs available for the men and women who had planned on working in the mines until retirement. People began to leave the area, following the promise of employment at distant mines or industrial centers. The local community health clinic scaled back its services and closed several adjunct clinics. Molly and her husband were fortunate as both kept their jobs. Over time, her husband became discontent and began an affair with a local woman. After the children left home, he asked for a divorce. Devastated, Molly gave in, allowing him to keep the house while she assumed legal responsibility for all of their debt. She filed bankruptcy and set about rebuilding her life. Her faith in God bore fruit. Her church became her primary source of support and her prayers were often answered. A church friend allowed her to buy the house she was renting, even though she was in the process of bankruptcy. Because she had no household appliances, her church purchased new ones for her. Her old car broke down and an out of state church acquaintance brought her a Chevy sedan. Molly saw the hand of God working though all of these things, and her religious beliefs were reinforced. Although they were divorced, Molly remained faithful to her husband, believing that he was her husband in the eyes of the Lord, and that God would bring them together again.

As the years passed, Molly developed health problems. She had miners' health insurance and access to health care. She held a lay persons knowledge of common health problems. Sporadically she sought advice for her health care concerns. She was diagnosed with diabetes, hypothyroidism, hyperlipidemia, and hypertension. In addition, she became overweight.

Molly was prescribed appropriate medications and received advice on life style modifications that would slow progression of the diseases. Molly would follow health care advice for a time; then for no apparent reason she would simply stop taking her medication and slip back into her old eating and living habits. She would continue on this course for a period of time, and then suddenly decide to resume her medications and life-style modifications, usually under the care of a different provider. Over the course of years Molly sought the advice of every provider working for the clinic. Many providers found Molly's behavior exasperating. Molly was intelligent and quite knowledgeable about her health care concerns. Her behavior seemed inexplicable.

While in her late forties Molly found a mass in one breast. Given her mother's history of breast cancer, Molly had reason to be concerned. A nurse practitioner had recently come to work at the clinic, and as the sole woman on staff, had assumed the role of "female provider", and was doing most of the women's health exams. Molly approached her in regard to obtaining a clinical breast exam and any further diagnostic testing and follow-up.

A review of her chart revealed Molly's sporadic approach to personal health. Periods of strict adherence to lifestyle modification and medication regimes alternated with long periods of non-adherence, which reverted back to adherence with a different provider. Molly herself was quite frank with the nurse, admitting that she never continued with her plan of care as she was advised, even when she knew that the advice given her was sound. At one visit, Molly's chief concern was a palpable breast mass. She stated that she had a hysterectomy years ago due to fibroid uterine tumors and had not had a clinical breast exam or mammogram since that time. She did perform breast self-exams. The breast mass had been there for over a month. She knew that she should have a breast exam and mammogram and preferred the female nurse practitioner to perform the exam and order the necessary imaging. She again told the nurse that her mother had had a double mastectomy due to breast cancer.

The nurse completed the exam and there was indeed a suspicious mass in one of Molly's breasts. Arrangements were made for a mammogram. Molly agreed to proceed as advised. She then told the nurse that she would be going to a prayer meeting at her church that night. She explained that she believed that God could heal her if she had faith. The nurse knew very little of faith healing, but saw no reason to alienate Molly by voicing her doubts. They agreed that Molly would go to her prayer meeting, but would also have the mammogram as planned. They would wait for the mammogram results before proceeding with a surgical consult. Both were comfortable with this plan.

The nurse saw Molly at the clinic the next day, and Molly asked to speak to her alone. She said that she had gone to a prayer meeting, and that a man had anointed her for healing and laid hands on her as he prayed. She felt the power of the Holy Spirit move upon her and fell out in the Spirit. Molly told the nurse that the mass was gone. God had healed her.

Based on the findings of the exam, the nurse was somewhat skeptical. Personally she did believe in a Higher Power, but did not believe as Molly did. The nurse also saw that this was very real to Molly, and that the episode had meaning to Molly that went beyond the specific matter of the breast mass. The nurse did not express her doubts as to the healing, but did ask if Molly would mind telling her a little more about it. Molly responded that she knew the nurse did not believe she had been healed. She did however tell the nurse the whole story of what had occurred the previous night. Molly commented that the nurse was the first provider that had ever listened to her about her beliefs. Molly agreed to follow through with the mammogram; although she now felt it was not needed.

The mammogram report came back negative, and another clinical breast exam revealed that the mass had disappeared. Molly thought her beliefs had been validated. The nurse thought that there was most likely a more scientifically logical reason for the disappearance of the mass. She kept her thoughts to herself, making no commitment one way or the other. The episode opened a line of communication between nurse and patient. Molly became comfortable talking to this nurse about her life and beliefs and began to see the nurse for her health concerns. Office visits became opportunities for Molly to talk to the nurse. Given that her belief in faith healing had a phenomenal effect on her attitude toward her personal health care, the nurse began to invite Molly to tell her stories about her religious beliefs, especially those concerning healing. Over

time the stories gave the nurse an idea of who Molly was, and the importance of holding on to belief systems grounded in her early childhood.

APPALACHIAN CULTURE

The need to understand Molly and the other patients that she served led the nurse to seek out literature on Appalachian culture. What she learned gave her a new perspective into the lives of both Molly and the rural community in which she practiced nursing.

Culture is an integral part of the environment. Culture is the learned, shared, and transmitted knowledge of values, beliefs, norms and life ways of a particular group that guides their thinking, decision making, and actions in patterned ways (Leininger, 1995). It is the technologies, traditions, speech patterns and customs, habits and mythology that are shared by a specific group (Shapiro, 1978). Culture imparts a group identity bringing a sense of belonging to a people. Culture is the context in which story is lived.

Appalachian culture was sculpted by both geography and the temperament of the original European inhabitants. Early Appalachian settlers often sought to avoid the religious, social, economic and political hierarchies of their previous environment. They were drawn to the isolation of the rugged mountainous Appalachian terrain (Jones, 1999; Weller, 1965). This self imposed, geographically protected solitude created an independent people who were marked by individualism and bound emotionally to their mountain homesteads (Jones, 1999). Their cherished solitude instilled in them an inherent distrust of outside influence and contacts, and reinforced their adherence to traditional life ways (Jones, 1999). The trials and hardship of life in the mountains was ultimately reflected in a fundamentalist spirituality that permeated the Appalachian perspective (Jones, 1999; McCauley, 1995). Limited contact with and distrust of the outside world necessitated the formation of strong, complex networks of kinship, cemented by an elevated sense of mutual loyalty and family duty (Jones, 1999) Appalachia remains a patriarchal society, where men generally assume the role of provider and women tend to stay at home, raising the children and running the household. In times of illness the caregiver responsibilities are delegated to the women (Stephens, 1994).

The stereotyping of Appalachians can be traced to the writings of travel journalists who came to Appalachia looking for stories of interest at the turn of the 20th century. They termed Appalachia as wild and uncivilized, uneducated and Godless, and highlighted the differences of the region from more urban mainstream America (Shapiro, 1978). These writers focused on the poverty, illiteracy, and isolation of Appalachian. Mainstream churches began to send missionaries, social workers and educators to Appalachia, hoping to bring salvation, civilization and education to this supposedly dysfunctional people (Williams, 2002).

In his 1965 book, *Yesterday's People: Life in Contemporary Appalachia*, sociologist Jack Weller formalized this pessimistic view of Appalachians. He found Appalachian culture to be traditionalistic, tied to the old ways of doing things, and uninterested in progress or change. He saw a paternalistic society, focused on family and fundamentalist religious beliefs. Weller wrote that Appalachians had little use for authority, tended to be fatalistic in their outlook, unwilling to move forward on their own initiative, and tended to blame fate for the hardships and afflictions in their lives. Weller's work helped stereotype Appalachian culture well into the 20th century (Shapiro, 1978).

The more cynical writers continued to promote their version of Appalachia, writing of ignorant hillbillies who went about life feuding and running moonshine. Other writers took a

more romantic view. They wrote of stalwart mountaineers who carved a living from the harsh but majestic mountains (Shapiro, 1978). Through the 20th century the media helped keep both stereotypes of Appalachians in the public mind. Television shows such as *The Beverly Hillbillies* and *Daniel Boone* reinforced both stereotypes. Later, movies such as *Deliverance* painted a dark, frightening picture of Appalachia (Williams, 2002).

The discovery of coal and timber in the late 1899's led to the wholesale purchase of Appalachian land by outside economic interest. These corporations then offered the lands' previous owners dangerous employment for scant financial return. In the coalfields, dangerous working conditions and low wages eventually sparked the development of the coal miners union and literal war with the outside owned coal companies (Williams, 2002). The miners succeeded in obtaining better wages and safer working conditions. Better roads, cheaper transportation, the media and internet have decreased the isolation of the region. In many areas the mines are now barren and persons needing gainful employment have left for the hopes of jobs in the bigger cities. Despite the efforts of state politicians to bring new industry to Appalachia, most of the area remains rural and many are unemployed or employed at minimum wage jobs without benefits (Williams, 2002). Lack of health care remains an issue in rural Appalachia with limited access to existing health care facilities and few health care professionals willing to locate in the area.

Appalachian mountain religious beliefs evolved from the teachings of the original British borderland settlers who first came to Appalachia seeking freedom from church authorities. The religious teachings and rites were primarily handed down from generation to generation in oral format (McCauley, 1995). The Bible is taken literally, and much of the preaching is done by laymen who compose their own sermons and site scripture from memory. The ballads and hymns used in church services are often folk songs or the original compositions of congregation members. The independent mountain churches also tend to believe that if there is a God, then logically there is a devil. Good and evil are not abstracts. God and the devil are distinct entities, and can interact and cause repercussions in the physical world here on earth. Many believe that the devil is out to gain souls just as God is out to save souls. They believe in trying to live a pure life. Some see illness and affliction as part of the devil's actions on this world.

In *Appalachian Mountain Religion: A History*, McCauley (1995) notes that when non-Appalachians are asked what comes to mind about religion in Appalachia the most common answer is serpent handling. In reality Appalachia is home to a variety of primarily Protestant Christian churches, as well as Catholic, Jehovah Witness, Jewish and Wiccan organizations. Central to Appalachian religious beliefs is the nondenominational, independent mountain churches (McCauley, 1995).

Independent mountain churches may be affiliated loosely with Holiness, Pentecostal, Church of God or Baptist denominations; but church leadership, financing, and doctrine are decided by the congregation. While these churches vary in doctrine, most hold to similar rites. Baptism by immersion, intermittent celebration of the Sacrament, foot washings, and instrument enhanced music are common among many independent churches. The independent Holiness, Church of God, and Pentecostal churches tend to believe in an active Holy Spirit that allows for faith healing, speaking in tongues, and physical transformation. When touched by the Holy Spirit, believers may dance, fall to the floor, or run the perimeter of a building (McCauley, 1995). Some believe that faith healing may be accomplished by individual prayer, prayer from the congregation or the anointment of the individual with Holy Oil or water. Some churches are more traditionalistic than others, stating that women should never cut their hair or wear anything

but dresses. Some are more extreme in their rites, which can include the handling of serpents, drinking of known poisons, or handling fire. While many mainstream Americans believe these more extreme rituals to be common in Appalachian churches, they are more the exception than the rule. Most believe that this life is followed by judgment day and then eternity, which may be spent in Heaven or Hell, depending on choices made here on earth. The author's journey in seeking a theoretical approach to guide culturally sensitive nursing practice led her to story theory.

STORY THEORY

Story Theory is connecting with self in relation through intentional dialogue to create ease (Liehr & Smith, 2008). The theory is based on the neomodernist view that humans are born into an ongoing story, or history (Reed, 1995). Life unfolds as personal stories, as humans interact with the environment and are shaped by experience. People are born into existing cultures, which provide belief systems on which an understanding of reality can be based. Values are developed based on the beliefs of the culture, and influence thinking, decision making, and action (Leininger, 1995). Culture bonds humans together as groups, imparting a sense of belonging (Shapiro, 1978). Culture provides a basis for customs, traditions and lifeways (Leininger, 1995). Culture is the context in which each human story is lived. Despite cultural similarities, no two persons share identical experiences or interactions with the environment. Thus each person has a unique reality, and the telling of this reality is expressed as a unique story. If one holds the belief that the focus of nursing is caring in the human health experience (Newman, Sime, & Corcoran-Perry, 1991), then nurses need to understand that experience from the view of the patient. One can impart a view of this experience by telling a story.

The nurse patient relationship is central to nursing practice. Story theory provides structure for use of story within the nurse patient relationship, allowing the nurse to examine the experience of the patient from the patient's perspective. Viewing the experience from the patient's perspective gives the nurse insight into what the experience means to that patient. It allows the nurse and patient to understand where the patient has been, where the patient is in the present, and the multiple possibilities open to the patient in the future.

Story theory makes three assumptions about persons:

1. Change as they interrelate with their world in a vast array of flowing connected dimensions
2. Live an expanded present where past and future events are transformed in the here and now, and
3. Experience meaning as a resonating awareness in the creative unfolding of human potential (Liehr & Smith, 2008, p. 209).

These assumptions ground the nurse's understanding of the process of change as persons interact with the multidimensional environment. An integral part of the environment is the culture in which they are immersed. People live in the present, but past and future connect in the present to create meaning and act as a catalyst to direct change. The past and future color cultural beliefs. One's culture is the lens through which beliefs and values influence decision making and guide health choices that determine the future.

Story Theory is composed of three interrelated concepts: (1) intentional dialogue (2)

connecting with self-in-relation, and (3) creating ease (Liehr & Smith, 2008). Intentional dialogue is the deliberate seeking of another's story concerning a complicating health challenge. This goes beyond collecting facts and clarifying events. The objective is to focus on what matters most to the story-teller, from the perspective of the teller. The nurse listens in true presence, is nonjudgmental and open to differences. The nurse listens closely to the details while attending to the overall story. The nurse listens not only to what is said, but to what is not said. Body language, silence, even the inclusion of something that does not at first glance seem pertinent may be part of the underlying meaning. Intentional dialogue also includes understanding that the story is ongoing and will be told as the teller determines. A health care challenge may seem to have a clear beginning and end, but in reality it is connected to what has been and what will come. The patient may attempt to impart the whole story, but part will always remain untold.

Connecting with self-in-relation includes personal history and reflective awareness (Liehr & Smith, 2008). Personal history is the story, the tale of how the patient came to be here and where the patient might be going. In reflective awareness, patient and nurse consider all aspects of the story, all roads that led to this place, and all roads that lead from this place. It is an expanded awareness not only of the roads chosen, but of roads that what might have been or still could be. It is a consideration of all possibilities. It includes a telling beyond actions and events. It is a telling of living a health challenge from the patient's unique perspective.

The concept, creating ease moves toward resolving a complicating health challenge. In re-remembering, pieces of the story are brought together in making sense where meaning was once hidden or confused. Flow in the midst of anchoring leads to a sense of security in newly understood meaning, with the awareness that life is dynamic and change moves us on (Liehr & Smith, 2008). It is taking the newly understood meaning and moving forward into the future, with a sense of serenity born of accepting the past as part of being, and moving forward with a newfound sense of purpose and understanding.

DISCUSSION

Molly's complicating health challenge was choosing in the context of deeply rooted religious convictions and established health practices. Given Molly's circumstances, it was not lack of opportunity, resources, motivation, or knowledge that kept her from following through with the medication regimen and lifestyle modifications that were central to maintaining her health. It was the stronghold of her religious convictions and cultural practices. As culture imparts the values and beliefs that guide thinking, decision making and action; it was imperative to understand her dilemma in choosing. The literature provided a basic understanding of Appalachian life-ways and story expanded an understanding of Molly's world.

Molly's story makes it clear that she is a product of her culture. Born and raised in the mountains, she has never seriously considered living anywhere else. The concept of home has deep meaning for her, including not just the geographical landscape, but the network of kin and friends that she has known all of her life. Molly has and is living her role as daughter, wife, mother and now grandmother. She follows the traditional ways of her people, polite but distrusting of outsiders, and fiercely proud and protective of her kin. Her religious experience includes: being touched by the Holy Spirit, speaking in tongues, prayer meetings, and anointment with holy water. Despite the divorce she still considers her marriage valid, and is faithful to her husband despite the efforts of others to get her to socialize and meet prospective mates. She also

remains an independent woman, working a full time job to meet her financial obligations while shouldering family responsibilities and remaining active in her church and community.

It was important to develop a nurse patient relationship that allowed for open communication. A nonjudgmental approach, which did not ridicule or disregard Molly's beliefs, was imperative. Rather than taking a stance for or against her religious beliefs, it was made known that the nurse had an open mind, and would not condemn or patronize Molly for holding to her beliefs. The nurse patient relationship was built on mutual respect.

Once Molly was comfortable in the nurse patient relationship, she was free to discuss things that she formally would not have discussed with other health care providers. Through intentional dialogue, conversations were deliberately guided toward the issue at hand. Molly was encouraged to talk about what mattered to her most, and it soon became clear that relationships with her mother and God had a strong hold on her approach to health care.

Connecting with self-in-relation includes personal history and reflective awareness (Liehr & Smith, 2008). In telling her personal history, Molly revealed that her relationship with her mother had been an important one. Molly returned again and again to the subject of her mother's religious convictions. It was clear that her mother was a dominant figure in her life. Molly revered her mother, holding her to be the epitome of strength, faith, goodness and womanly virtue. Most of the stories Molly told of her mother involved the church or faith. Many of those stories are related to health or healing. In her youth, Molly's mother was her caregiver, tending to illnesses, taking her to both doctors and church in search of healing. She had witnessed her mother's healing touch again and again. Her mother taught her that God could heal all things, yet her mother utilized the health care system for Molly and her siblings. Toward the end of her life, her mother turned to the health care system for her ailments. This was a contradiction. Molly was aware of it.

In creating ease, the nurse and patient tie things up and move toward acceptance and change (Liehr & Smith, 2008). The telling of her story to the nurse gave Molly a safe arena in which to express her beliefs. In re-remembering over time, Molly brought the pieces of her past together. She recognized the conflict between her religious beliefs and what she found to be true in the world. She came to understand that she had the tendency to see the situation in black and white. If one had faith, God would heal. Therefore there was no need for health care, as long as one had faith. Molly could not doubt her mother's faith. She did however, doubt her own. At times, Molly believed she lacked the faith necessary for healing. Other times she saw her illnesses as a burden God had placed on her, and thought it was a test of her faith to bear them. She often felt guilt and remorse no matter which path she chose. On the one hand she believed she was failing God; on the other hand she believed she was failing herself by not following health care advice.

Application of story theory guides the movement toward resolution, but also acknowledges that one's story continues even as it is being told. Molly shared her story over the course of many office visits. While she saw the nurse more frequently than she had the other providers, she still on occasion would stop her health care treatment and rely solely on faith. When she did return for treatment she no longer experienced the need to change providers, and would return to the nurse who understood the evolving story plot, thereby keeping continuity of care and reaffirming the nurse-patient relationship. As nurse and patient came to know each other Molly was comfortable bringing additional pieces of her story to the nurse patient dialogue. She found it helpful to pray prior to making any major health related decision, and eventually said short prayers in the office. She continued to pursue her faith healing practices, keeping the

nurse aware of both victory and disappointment. Molly's story lives on and in the evolution of the story, the nurse has become a significant person in helping her to resolve dilemmas in health care choices.

CONCLUSION

This scholarly journey of a nurse practitioner into the realm of religious and cultural perspectives and middle range theory offers a model for advanced practice nursing. Story theory (Liehr & Smith, 2008) in nursing practice gives structure to using story to view the world from the patient's perspective. An understanding of culture and religious beliefs provides understanding of the context in which the story unfolds. Listening attentively to what matters most in dialogue enables the caring/healing process that is essential to promoting health.

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CYNTHIA DENICE GOBBLE – 1958-2009

On a cold winter morning, in a rural coal mining community, family and friends gathered in a chapel to celebrate the life of Cynthia Denice Gobble who died on January 5, 2009. The pastor spoke lovingly of a quiet yet determined woman who dedicated her life to serving others in rural Appalachia. Her life story was characterized by a deep faith that served as the foundation of her love for rural people and rural places. She cherished the Appalachia way of life and was passionate about upholding beliefs and traditions. She held closely those she served as nurse and spoke of them as "my people". Tributes in the chapel reflected Denice's love of knowledge, strong connectedness to West Virginia University, and long history in nursing. A Master's Degree diploma, a statue of Florence Nightingale, a blue and gold WVU throw, a handmade

quilt, and flowers adorned the chapel. At the time of her death she had completed all of the course work to earn the Doctor of Philosophy degree in nursing. This paper gives voice to her tireless journey to integrate theory, practice and research. It is published here to honor her commitment to contribute to the development of nursing science in promoting the health of rural people. This paper serves as a part of her legacy: a gift she leaves to her family, patients, colleagues, classmates, and faculty.

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